Supreme Court, U.S.
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No. 1

In The
Supreme Court of the United States

PAUL J. MEYERS, M.D.,
Petitioner,

v.

RIVERSIDE HOSPITAL, T/A RIVERSIDE REGIONAL MEDICAL CENTER; RUDOLPH FREEMAN, JR., M.D.; RICHARD HOEFER, M.D.; CHARLES FAULK, M.D.; BRUCE KAUDER, M.D.; AND PAUL REIN, M.D.
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Does the trial court or the jury decide whether a hospital's professional review action met the standards of 42 U.S.C. § 11112(a) and, therefore, whether the hospital is immune under 42 U.S.C. § 11111(a)(1)?

2. On a motion for summary judgment, does the trial court apply a deferential standard to determine whether a physician has produced sufficient evidence to rebut, by a preponderance of the evidence, the presumption of immunity under 42 U.S.C. § 11112(a)?

3. Does 42 U.S.C. § 11113 authorize an award of attorney's fees where a plaintiff's underlying claim is meritorious and plaintiff's challenge to defendant's presumption of immunity involves a case of first impression in the jurisdiction?

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OPINIONS BELOW

The decision of the Virginia Supreme Court, dated October 24, 2007, finding no reversible error in the trial court's decision, is reproduced at App. A, 1a.

The letter opinion of the Circuit Court for the City of Newport News, dated June 12, 2006, denying plaintiff's motion for reconsideration and granting defendants' motion for reconsideration and sustaining their demurrer to plaintiff's *Third Amended Motion for Judgment*, is reproduced at App. B, 3a-5a. The order entered by the court on September 15, 2006 dismissing plaintiff's complaint with prejudice, is reproduced at App. C, 6a-8a. Excerpts from the hearing that contain the trial court's ruling awarding defendants attorney's fees is reproduced at App. D, 11a, and the court's final order, entered on October 31, 2006, is reproduced at App. E, 12a-14a.

The trial court's letter opinion, dated July 27, 2005, holding that plaintiff failed to rebut the presumption of immunity and that defendants were immune under 42 U.S.C. § 11111(a)(1), but overruling the demurrer to the *Third Amended Motion for Judgment*, is reproduced at App. F, 15a-16a. The order entered by the court on August 5, 2005 is reproduced at App. G, 17a-19a.

JURISDICTION

The trial court entered a final order in this case on October 31, 2006. The Virginia Supreme Court refused plaintiff-appellant's Petition for Appeal on October 24, 2007. This petition is timely filed under Supreme

Court Rule 13.1, and this Court has jurisdiction pursuant to 28 U.S.C. § 1257(a) to review the decision of a lower state court that is subject to discretionary review.

Under Virginia law, litigants do not have a right of appeal to an intermediary appellate court from civil cases sounding in tort or contract, *see* Va. Code §§17.1-405 and 406 (defining the appellate jurisdiction of the Virginia Court of Appeals), and must petition the Virginia Supreme Court for appeal, *see* Va. Sup. Ct. R 5:7. Refusal of a Petition for Appeal is a judgment on the merits, *see Saunders v. Reynolds*, 204 S.E. 2d 421, 424 (Va. 1974), although if, as in this case, the court does not write an opinion, the decision has no precedential value, *see Sheets v. Castle*, 559 S.E. 2d 616, 619 (Va. 2002).

STATUTORY PROVISIONS INVOLVED

The relevant statute is the Health Care Quality Improvement Act, 42 U.S.C. §§ 11111(a), 11112(a), and 11113. These are reproduced at App. H, 21a-24a.

STATEMENT OF THE CASE

This case raises the questions of who decides whether a hospital's professional review action met the requirements for immunity under the Health Care Quality Improvement Act, ("HCQIA" or "Act") and whether a deferential standard should be applied to make that determination. These questions have important consequences for the medical profession and the public because how they are decided will affect how peer review is practiced.

Whether immunity under the HCQIA is a question of law to be decided by the trial court, like immunity under 42 U.S.C. § 1983, or a mixed question of fact and law to be decided by the jury, like the standard of medical care, has divided the federal circuits. *See Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1333-34 (11th Cir. 1994), *cert. denied* 514 U.S. 1019 (1995) (immunity a question of law); *Singh v. Blue Cross / Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 34-35 (1st Cir. 2002) (immunity a mixed question of fact and law). In this case, the trial court treated defendants' immunity as a question of law for the court to decide, and applied an incorrect deferential standard inconsistent with the standard Congress enacted and federal appellate courts and courts of last resort of other States have applied.

I. BACKGROUND ISSUES

Congress enacted the immunity provisions of HCQIA to encourage physicians to engage in effective peer review of their colleagues as a means to improve the quality of medical care and protect patients. 42 U.S.C. § 11101(5), App. H, 21a. Without such protection, Congress believed that

> the threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discouraged physicians from participating in effective professional peer review.

Id. at § 11101(4); App. H, 20a-21a; *Gordon v. Lewiston Hosp.*, 423 F.3d 184, 202 (3d Cir. 2005) ("At its heart,

the HCQIA was intended to deter antitrust suits by disciplined physicians").

For immunity to attach under 42 U.S.C. § 11111(a)(1), professional review actions[1] must meet the due process requirements and reasonableness standards of 42 U.S.C. § 11112(a). *See Brown v. Presbyterian Health Care Services*, 101 F.3d 1324, 1333 (10th Cir. 1996) These standards are objective. *See Singh*, 308 F.3d at 32 ("Our sister circuits have uniformly applied all the sections of § 11112(a) as objective standards). There is a presumption that professional review actions meet these requirements and standards, but the physician may rebut the presumption by a preponderance of the evidence. 42 U.S.C. § 11112(a), App. H, 23a.

These standards seek "to balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action". *See Bryan*, 33 F.3d at 1322 n.3. Congress cut back the scope and level of immunity in the original bill in response to concerns that the immunity would be misused for discriminatory, anticompetitive and other antisocial reasons. *See* Charity Scott, *Medical Peer Review, Antitrust, and The Effect of Statutory Reform*, 50 Md. L. Rev. 316, 330-332 (1991) (describing amendments to the original bill to limit the scope of immunity). For example, the standard for rebutting the presumption of immunity was reduced from clear and convincing evidence in the

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[1] *See* App. H, 26a-27a, 42 U.S.C. § 11151(9) (defining professional review action).

original bill, *see* H.R.5110, Sec. 102(a), App. I, 30a-31a, to the preponderance of the evidence, *see* 42 U.S.C. § 11112(a), App. H, 23a.

The statutory presumption merely shifts the burden to the physician to prove that a hospital's actions breached the statutory standards. *See* Scott, supra at 348 (explaining that the presumption of immunity, like the 'presumption of innocence', is not a true legal presumption at all). It does not change the burden of production,[2] who decides the question of immunity, or how the evidence should be reviewed on a motion for summary judgment asserting immunity under HCQIA. *Id.* at 381 ("judge must decide, not whether she believes that the defendants more probably than not did not comply with the four immunity standards, but rather whether a rational jury could so find on the evidence presented by the plaintiff"); *Reeves v. Sanderson Plumbing Products*, 530 U.S. 133, 149-51 (2000) (court should credit non-moving party's evidence and only the evidence of the movant that a jury is required to believe) (not a HCQIA case). Never the less, some courts have misunderstood the presumption to create what

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[2] The forum's law of summary judgment is applied. *See Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 944 (Pa. 2001). In Virginia, summary judgment is disfavored. *Slone v. General Motors Corp.*, 457 S.E.2d 51, 52 (Va.1995) (quoting *Turner v. Lotts*, 457 S.E.2d 765, 766 (Va. 1992). Where conflicting inferences can be drawn from undisputed facts, those favoring the non-moving party must be drawn, and if such inferences would allow the non-moving party to prevail at trial, summary judgment is improper. *See Pugh v. Commonwealth*, 292 S.E.2d 339, 341 (Va. 1982).

amounts to a 'minimal basis' standard that raises the level of immunity, protects abuses of the peer review process, and disturbs the balance Congress deliberately struck by its amendments to the bill.

> I must concur in the result reached in the majority opinion because HCQIA sets such a low threshold for granting immunity to the hospital's so called peer review. Basically, as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, whether legitimate or not, they are immune from liability. Unfortunately, this may leave the hospitals and review board members free to abuse the process for their own purposes without regard to quality medical care.
>
> Unfortunately, the immunity provisions of HCQIA sometimes can be used, not to improve the quality of medical care, but to leave a doctor who is unfairly treated without any viable remedy.

See Meyer v. Sunrise Hosp., 22 P.3d 1142, 1153-54 (Shearing, J., with whom Rose, J., agrees, concurring); *accord* Note: *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. Contemp. Health L. & Pol'y 239, 252-53 (2001) (discussing evidence that peer review is often misused but protected by federal and state immunity statutes).

In this case, the Virginia Supreme Court's decision has eroded the statutory safeguards against misuse of the peer review process still further by treating the question of immunity as one of law for the court to decide, and by substituting the judicially created doctrine of non-review the court adopted in *Khoury v. Community Memorial Hospital, Inc.*, 123 S.E.2d 533 (Va.1962) and *Medical Center Hospital v. Terzis*, 367 S.E.2d 728 (Va. 1988) for the objective reasonableness standard Congress enacted. *See* 42 U.S.C. § 11112(a), App. H, 23a. Under this standard, any action a hospital takes on a physician's privileges will be deemed objectively reasonable so long as the hospital offers the physician a hearing, and abuses of the peer review process protected. *See* App. J, 33a, ¶ 4 ("If due process is afforded through an administrative action that satisfies HCQIA, then that's what you are entitled to and immunity flows from that").

II. BACKGROUND FACTS

Riverside Regional Medical Center, plaintiff's employer, summarily suspended all of plaintiff's clinical privileges on March 1, 2000, and on July 25, 2000, the Medical Executive Committee ("MEC") recommended that all his privileges be revoked. This law suit arises from these actions.[3]

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[3] Riverside recruited plaintiff in 1991 to provide hands-on surgical training to its residents after its residency program in obstetrics and gynecology ("Ob-Gyn") was placed on probation. Because of plaintiff's surgical and teaching skills, the residents selected plaintiff to supervise their most difficult cases, and most of plaintiff's surgical cases were high-risk indigent patient with complex surgical problems. App. K, 36a-39a.

Plaintiff's suspension was based on five intraoperative complications that occurred over a three and a half month period. All involved endoscopic procedures, none resulted in a mortality or permanent injury, and four resulted in no adverse outcomes at all. An added justification for the suspension was that plaintiff's *endoscopic* privileges had been suspended on December 11, 1998 and he had recently completed a proctorship imposed after that suspension.[4] In his report, plaintiff's proctor stated:

> In my opinion, Dr. Meyers is a competent and talented endoscopic surgeon, and is a valuable part of our local medical community. I have never understood why his privileges were restricted, as the apparent result of his having experienced recognized and accepted surgical complications, which were appropriately managed...Indeed, our medical community could profit considerably from Dr. Meyers sharing his skills with his colleagues, something he willingly does.

See App. L, 41a-42a.

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[4] The allegation was also made that plaintiff had asked a nurse to alter the medical records of a patient. The ad hoc committee interviewed the nurse and found no evidence to support this allegation. Never the less, the MEC rejected the ad hoc committee's findings and a letter making the allegation that plaintiff had asked a nurse to alter a patient's medical records was published to another hospital where plaintiff had privileges in gynecology.

During the investigation that led up to the imposition of the proctorship, several documents were generated that contained fabrications, contrived criticisms, and false or misleading statements about plaintiff and his cases. Plaintiff was never provided these documents at the time because Riverside denied plaintiff a hearing on the 1998 suspension notwithstanding that it was imposed for more than 30 days. *See* 42 U.S.C. § 11111(c)(1)(B), App. H, 24a. The ad hoc committee appointed to investigate plaintiff following the 2000 suspension ("ad hoc committee") relied on these documents and accepted them at face value.

The ad hoc committee did not review the medical records of a single case on which the suspension was based or those of any other of plaintiff's patients. It relied exclusively on the report of an external reviewer who did not review two of the five cases on which the suspension was based, and who was provided incomplete medical records on almost all the cases he reviewed. App. M, 44a, ¶ 8 ("I had a lot of things missing in almost every case"). On being apprized of the missing information at his deposition, the reviewer withdrew almost all the criticisms in his report. *Id.*, 45a. The ad hoc committee met with plaintiff but it never discussed the cases on which the suspension was based. The plaintiff was not provided with a copy of the reviewer's report until after he met with the ad hoc committee, and could not raise the inaccuracies in the report himself.

Riverside was, however, on notice that the reviewer's report was flawed. Some members of the ad hoc committee knew that one of the reviewer's main

criticisms was incorrect, yet continued to rely uncritically on the report and accepted it at face value. In addition, the then Chairperson of Obstetrics and Gynecology, Dr. Karen Bruder, after reading the report, informed the Vice President of Medical Affairs, defendant Rudolph Freeman, Jr., M.D., who oversaw the investigation, that there were many problems with the report. She asked Freeman to see the medical records on which the report was based but Freeman denied her request.

In a report to the MEC, the ad hoc committee stated that no objective standards existed for laparoscopic case selection or an acceptable rate of laparoscopic complications. The committee concluded that the plaintiff's judgment regarding endoscopic procedures was questionable, probably overly aggressive and resulted in an increased number of complications, but expressly stated that its conclusions were subjective and based on the reviewer's report and documents the committee had reviewed.[5] The committee expressly stated that it made no conclusions about plaintiff's obstetrical and open (non-laparoscopic) surgical cases, and made no recommendations as to what action, if any, should be taken on plaintiff's laparoscopic privileges.

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[5] One of these documents contained the false statement that plaintiff's laparoscopic complication rate for 1998 was 15%. This figure was arrived at by including in the rate calculation all of plaintiff's complications but only about a third of his laparoscopic cases.

On July 25, 2000, the MEC recommended to the Board of Trustees that all of plaintiff's clinical privileges be revoked without reviewing any medical records, interviewing plaintiff or conducting any other investigation of its own. On June 4, 2001, after a hearing lasting several days, a hearing panel determined that plaintiff's laparoscopic complication rate was, if anything, lower than reported in the medical literature, and recommended reinstatement of all plaintiff's privileges. However, because plaintiff had by that time not operated for over a year, the panel suggested that he be proctored for some cases but the MEC refused to accept this reason for the proctorship and insisted that it be imposed because plaintiff's clinical judgment was impaired.

III. DECISIONS OF THE TRIAL COURT

Defendants first asserted immunity under HCQIA in a demurrer to plaintiff's *Third Amended Motion for Judgment* (*TAMFJ*) alleging multiple counts of defamation per se and tortious interference with advantageous relationships.[6] Relying on *Bryan*, 33

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[6] Retired Judge John E. Clarkson, sitting by designation of the Virginia Supreme Court, sustained defendants' demurrer to the *First Amended Motion for Judgment* on the pleadings. Defendants did not assert immunity under HCQIA at that time. After plaintiff filed a *Second Amended Motion for Judgment*, the case was stayed for over eighteen months due to insolvency of defendants' insurer. After the case was reinstated on the court's active docket, plaintiff amend his complaint by leave of court and dismissed a party and contract based claims.

F.3d at 1331-2, 1337, defendants argued that the question of their immunity was one of law for the court to decide and that, to decide that question, the court should defer to the judgment of the peer reviewers rather than substitute its judgment for theirs. Plaintiff contended that the standard was objective, not deferential, and that the question of immunity was one of fact to be decided by the jury. By leave of court, plaintiff submitted post-hearing briefs on these issues.

The trial court, following Eleventh Circuit precedent, decided that defendants were immune under 42 U.S.C. § 11111(a)(1) and that plaintiff had failed to rebut the presumption of immunity by a preponderance of the evidence. App. F, 16a. Never the less, the court overruled defendant's demurrer to the defamation counts holding that if, as plaintiff had alleged, defendants made false statements with

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In his *Third Amended Motion for Judgment*, plaintiff alleged an unusual amount of factual detail in support of his claims, and attached supporting documents, to evidence that his allegations of fabrication and false statements were not bare assertions, because during the hearing on the demurrer to the *First Amended Motion for Judgment*, the court stated that it had "a hard time believing that a group of doctors were so evil". *See* App. N, 48a, ¶ 3. Further documents were attached by motions craving oyer by both parties. App. G, 18a, ¶ (a). Defendants attached expert reports on which the hospital never relied for the recommendation to revoke all of plaintiff's privileges, and affidavits which plaintiff rebutted by his own third party affidavits.

knowledge of falsity, they would lose all immunity. App. G, 18a, ¶ (b).[7]

Six months later, defendants moved the court to reconsider its ruling based on the holding and reasoning of *Jenkins v. Methodist Hospital of Dallas*, No. 3:02-CV-1823-M, 2004 U.S. Dist. LEXIS 28094 (N.D. Tex. August 18, 2004). Defendants contended that 42 U.S.C. § 11111(a) provides two independent bases of immunity to persons who provide information to a professional review body, and that the court, having found that the hospital was immune under 42 U.S.C. § 11111(a)(1), erred in overruling their demurrer because even if anyone had provided false information with knowledge of falsity, they would still be immune under 42 U.S.C. § 11111(a)(1)(D), even if they lost immunity under 42 U.S.C. § 11111(a)(2).

Before ruling on the motion, the trial court granted plaintiff' leave to file a motion to reconsider the court's original ruling that defendants were immune under 42 U.S.C. § 11111(a)(1), and to submit evidence obtained through discovery since the original ruling on the demurrer. *See* App. J, 34a, ¶ 4 and 35a, ¶ 4. The court denied plaintiff's motion, and sustained defendants' demurrer without further leave to amend. App. C, 8a, ¶ 1.[8] Although the trial court found *Jenkins* "helpful or

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[7] The court dismissed the tortious interference count with prejudice, App. G, 18a, ¶(c), and plaintiff did not appeal that decision.

[8] Under Virginia law, when a trial court considers facts in ruling on a demurrer, thereby treating it as if it were a motion for summary judgment, the Virginia Supreme Court will review the

decisive", App. B, 4a, ¶ 2, it did not sustain defendants' demurrer based on the holding of *Jenkins* but on the factual finding that plaintiff's evidence contained only examples of false statements made with reckless disregard of the truth and not with knowledge of falsity, *id.*, 5a, ¶ 1.The court reaffirmed its earlier ruling that plaintiff failed to rebut the presumption of immunity, and specifically held that defendants had conducted a reasonable investigation. *Id.*, 4a, ¶ 4.

Defendants then moved for attorney's fees pursuant to 42 U.S.C. § 11113. Without making any findings of fact, the court held that plaintiff's law suit was "unreasonable and without foundation brought". App. D, 11a, ¶ 2.

IV. DECISION OF THE VIRGINIA SUPREME COURT

Plaintiff raised the question of whether immunity should be one of law for the court to decide in his reply brief as one subsumed in, and anterior to, the question of whether the court should decide immunity by applying a deferential standard. The defendants raised the question of deference in their brief opposing the petition for appeal by arguing that *Bryan* required federal courts to apply a deferential standard under 42 U.S.C. § 11112(a), consistent with the standards adopted by the Virginia Supreme Court in *Khoury*, 123 S.E.2d at 539 & *Terzis*, 367 S.E.2d at 730. Plaintiff

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trial court's ruling under a summary judgment standard so long as the non-moving party - i.e. the plaintiff in this case - fails to object. *See Shelton Motor Co. v. Miller*, 544 S.E.2d 345, 348 (2001).

contended that defendants misconstrued *Bryan*'s *dictum*. By finding no reversible error in the judgment, App. A, 1a, the Virginia Supreme Court adopted this deferential standard and treated the question of immunity as one of law to be decided by the trial court.

REASON FOR GRANTING PETITION

I. THE FEDERAL CIRCUITS ARE SPLIT OVER WHETHER THE COURT OR JURY SHOULD DECIDE THE QUESTION OF IMMUNITY.

Since "questions of law do not turn upon the satisfaction of evidentiary burdens", whether the standards of section 11112(a) have been met should be a question of fact for the jury to decide. *See Reyes v. Wilson Mem. Hosp.*, 102 F.Supp.2d 798, 810 (S.D. Ohio 1998). And since a hospital's immunity under 42 U.S.C. § 11111(a)(1) depends solely on whether its action(s) met the objective standards of section 11112(a), whether the standards of section 11112(a) have been met and whether a hospital is immune are the same questions framed in different ways.

The Ninth Circuit correctly framed the question to be decided on a motion for summary judgment asserting immunity under 42 U.S.C. § 11111(a)(1) as "Might a reasonable jury, viewing facts in the best light for [the plaintiff], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)", and focused the court's inquiry on the sufficiency of the *physician*'s evidence to overcome the statutory presumption. *See Austin v. McNamara*, 979 F.2d 728,

734 (9th Cir. 1992). Although *Bryan* adopted the Ninth Circuit's formulation of the question to be decided on a motion for summary judgment and its focus on the sufficiency of the *physician's* evidence, the court treated the question of immunity as one of law to be decided by the court, analogous to the qualified immunity under 42 U.S.C. § 1983. *See Bryan*, 33 F.3d at 1333-34. Under Eleventh Circuit law, juries are permitted to decide only "subsidiary questions of fact", not the question of immunity. *Id.* The analysis required by *Bryan* created some confusion among the lower courts. *See Reyes*, 102 F.Supp.2d at 810 ("In permitting the issue of HCQIA immunity to be resolved on summary judgment...courts have not always been careful in their explanation of the analysis involved).

The First Circuit has rejected the Eleventh Circuit's analogy between the qualified immunities created by 42 U.S.C. § 11111(a)(1) and § 1983, and the court's holding that the role of the jury in the determination of a hospital's immunity under 42 U.S.C. § 11111(a) "is limited to disputes over subsidiary issues". *Singh*, 308 F.3d at 34. Relying on this Court's functional approach in *Miller v. Fenton*, 474 U.S. 104, 114 (1985), the First Circuit treats the question of whether the physician rebutted the presumption of immunity as a mixed question of fact and law to be decided by a jury, aided, if necessary, by expert testimony as to what reasonable standards of peer review require. *See Singh*, 308 F.3d at 34-35; *accord Brown*, 101 F.3d at 1334 n. 9 (allowing expert to testify that the hospital's investigation was "unreasonably narrow and did not provide a reasonable basis for concluding that the physician

posed a threat to patient safety"). Under First Circuit law, a trial court is permitted to grant summary judgment only "if the evidence of reasonableness within the meaning of the HCQIA is so one-sided that no reasonable jury could find that the defendant health care entity failed to meet the HCQIA standards". *Id.* at 36. If "questions exist regarding the reasonableness of a peer review action", the question is submitted to the jury to decide. *Id.* at 35. The Tenth Circuit's decision in *Brown* is consistent with First Circuit law.

In this case, the trial court recognized that whether the court or the jury should decide the question of defendants' immunity was at issue, and that who decides the question could be outcome determinative. *See* App. O, 51a, ¶ 5 ("I'm worried about who makes the decision...You know, quite frankly, if I was to make it, I think they did everything reasonably....but I am not sure I make that decision"). After considering post-hearing memoranda, the court decided the question of immunity itself. In its letter opinion of July 27, 2005, the court stated,

> I find from the exhibits and arguments of counsel that the standards for professional review actions have been fulfilled. The standards necessary for protection have not been rebutted by a preponderance of the evidence.

App. F, at 16a, ¶ 2. In its letter opinion of June 12, 2006, the court stated,

> I have previously found, and again today find...that the process and standards for professional review of the defendant Hospital under the Health Care Quality Improvement Act ("HCQIA")...were reasonable...

App. B, 4a, ¶ 3.

> I further find that defendants made a reasonable attempt to obtain the facts, the investigation was reasonable and that plaintiff did not rebut defendants' presumption of immunity under 42 VSCS (sic) § 1112(a) (sic) by a preponderance of the evidence.

Id. ¶ 4. By finding no reversible error in the trial court's ruling, the Virginia Supreme Court affirmed that the question of immunity under 42 U.S.C. § 11111(a)(1) should be treated as one of law for the trial court to decide. App. A, 1a.

The reasonableness of peer review should not be decided as a matter of law because it is context dependent, and standards of peer review, like medical standards, can be expected to change with time. As this Court has noted,

> individual pieces of evidence, insufficient in themselves to prove a point, may in cumulation prove it. The sum of an evidentiary presentation may well be greater than its constituent parts.

Bourjaily v. United States, 483 U.S. 171, 179-80 (1987). If immunity is treated as a question of law, the evidence rejected as insufficient to rebut the

presumption of immunity in a particular case will tend to create precedent barring the use of the same genre of evidence notwithstanding that in a different context the probative force of the same evidence may be different or, when combined with other pieces of evidence, may render the evidence as a whole sufficient to rebut the presumption of immunity by a preponderance of the evidence.

II. THE REASONABLENESS STANDARDS OF 42 U.S.C. § 11112(a) ARE NOT DEFERENTIAL.

The defendants urged the courts to apply a deferential standard under 42 U.S.C. § 11112(a), and, relying on *Bryan*, 33 F.3d at 1337, argued that HCQIA prohibited the courts from substituting their judgments for those of the hospital and its peer reviewers. *See* App. J, 33a, ¶ 4 ("If Your Honor gets into examining the facts again, Your Honor is doing exactly what Congress and the courts uniformly have said, and that is we're not here to substitute our judgment for that of the hospital body...Your Honor said...I'm not going to second guess the doctors"). In their briefs supporting the demurrer and opposing the petition for appeal, the defendants asserted:

> Under the Act, the Court's role 'is not to substitute [its] judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges'. *Id.* at 1337 (citation omitted).

> The federal courts' reluctance to inject themselves into hospital's affairs echoes the Virginia Supreme Court's deference to persons charged with the task of governing those institutions. *See Khoury v. Community Memorial Hospital, Inc.*, 203 Va. 236, 245, 123 S.E.2d 533, 539 (Va. 1962) ('[W]hen the trustees of a private hospital, in their sound discretion, exclude a doctor from the use of the facilities of the hospital, the courts are without authority to nullify that discretion by injunctive process'); *see also Medical Center Hospital v. Terzis*, 235 Va. 443, 446-47, 367 S.E.2d 728 (Va. 1988) (*Khoury* articulates a rule of non-intervention in a hospital's internal affairs).

This argument misconstrues the nature of the deference referred to in *Bryan*, 33 F.3d at 1331, and the inquiry required by 42 U.S.C. § 11112(a) to determine if the presumption of immunity has been rebutted by a preponderance of the evidence.

The language the defendants quoted from *Bryan* was taken from *dictum* in *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750, 756 (W.Va 1991), *cert. denied*, 502 U.S. 863 (1991),[9] *see Bryan*, 33 F.3d at 1337, and referred to a prudential doctrine of non-review that is "not grounded in statutory or constitutional provisions", *see Feyz v. Mercy Mem. Hosp.*, 719 N.W.2d 1, 8 (Mich. 2006), but was

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[9] In *Mahmoodian*, plaintiff was seeking an injunction to enjoin the hospital from revoking his privileges, and the case was not decided based on HCQIA immunity.

developed by State courts in response to attempts by aggrieved physicians to reverse adverse decisions on their hospital privileges through injunctive relief, *see Sandler v. Dimensions Healthcare Corp.*, 836 A.2d 655, 662-67 (Md. 2003) (reviewing case law on the non-review doctrine).[10] Several jurisdictions have modified the doctrine, *id.* at 664, and the Michigan Supreme Court has abandoned the doctrine altogether, *see Feyz*, 719 N.W.2d at 16-17. After the Virginia Supreme Court adopted the doctrine in *Khoury*, 123 S.E.2d at 539, the Virginia General Assembly modified *Khoury* by requiring hospitals to state their reasons in writing for refusing or later revoking staff privileges. *See* Va. Code § 32.1-134.1 (2006). However, the Virginia Supreme Court interpreted the statute narrowly and held that it "unambiguously limited the court's review to the question of whether the 'reason or reasons stated' are within the statutory criteria...[and did not] authorize a judicial review of either the merits of the hospital's complaint or the procedures the hospital employed in reaching its conclusion". *See Terzis*, 367 S.E.2d at 730.

The standard of review adopted in *Khoury* as modified by *Terzis* is inconsistent with the objective reasonableness standards of 42 U.S.C. § 11112(a). The

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[10] These equitable actions were disfavored, initially on the basis of the business judgment rule, *Sandler*, 836 A.2d at 663; *Natale v. Sisters of Mercy of Council Bluffs*, 52 N.W.2d 701, 709 (Iowa 1952); *Khoury*, 123 S.E.2d at 539 (holding that doctor had no constitutional or statutory rights which would authorize a court to nullify a hospital's decision denying the doctor privileges at the hospital) and later on policy grounds, *see Owens v. New Britain Gen. Hosp.*, 643 A.2d 233, 241 (Conn. 1994) (citing cases).

non-review doctrine is not applicable to common law causes of actions, *see Cooper v. Delaware Valley Med. Ctr.*, 654 A.2d 547, 552 (Pa. 1995) (distinguishing cases seeking injunctions and damages under tort and contract theories), and was never intended to immunize hospital administrators or members of a hospital's medical staff from liability for tortious conduct, *see Natale*, 52 N.W.2d at 709 (acts or omissions of a hospital's board of trustees that wrongfully injured another would incur liability); *Clark v. Columbia / HCA Info. Servs.*, 25 P.3d 215, 220 (Nev. 2001) ("the tangential involvement of the peer review process does not foreclose judicial intervention in the types of disputes normally dealt with in the courts"). Nor does HCQIA authorize deference to governing bodies or peer reviewers in deciding whether a hospital's actions breached the reasonableness standards of 42 U.S.C. § 11112(a). *See* Scott, supra at 403. On the contrary, by amending H.R. 5110 to ensure that an objective standard of reasonableness is applied and subjective good faith of the reviewers would not be deemed sufficient for immunity under HCQIA to attach, Congress effectively rejected a deferential standard of review under section 11112(a). *See Austin*, 979 F.2d at 734; App. I, 30a, Sec. 102(a)(1); 42 U.S.C. § 11112(a)(1), App. H, 23a. Deference is implicit in the good faith standard Congress expressly rejected because under that standard peer reviewers acting in good faith are immunized for any actions they deem appropriate regardless of their objective reasonableness.

Nor can *Bryan* be read to require trial courts to substitute this prudential doctrine for the statutory standards Congress enacted. *Bryan* stands only for the

proposition that once a court determines that plaintiff's evidence is insufficient to rebut the presumption of immunity, HCQIA does not authorize the court to determine what particular disciplinary action the hospital should take. *Bryan*, 33 F.3d at 1337 (physician did not challenge events that prompted termination of privileges, only contended that they did not warrant such severe punishment); *accord N. Colo. Med. Ctr. v. Nicholas*, 27 P.3d 828, 840 (Colo. 2001) (stating, "[w]here the requirements of section 11112(a) are fulfilled, we need not extend our inquiry further"); *Meyer v. Sunrise Hosp.*, 22 P.3d 1142, 1151 (Nev. 2001) ("issue is not whether...a judge or jury believes that the penalty was too harsh").

In as much as HCQIA does not apply to injunctions, *see Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1031 (4th Cir. 1994), it is true that the intent of HCQIA was not to replace the judicially created non-review doctrine. However, a judicially created doctrine cannot replace or modify the standards in a federal statute, and, hence, support a deferential standard of review under 42 U.S.C. § 11112(a).

It is also true that HCQIA does not preempt state law that affords additional or greater protection to peer reviewers, *see* 42 U.S.C. § 11115(a); App. H, 25a, and, therefore, nothing in HCQIA prevents States from enacting statutes that provide immunity based on a deferential standard if they wish to do so. Virginia has done just that by enacting legislation that immunizes peer reviewers for any good faith actions and that requires clear and convincing evidence to prove bad faith. *See* Va. Code § 8.01-581.16. But this is precisely the standard in H.R. 5110 that Congress expressly

rejected when it enacted 42 U.S.C. § 11112(a). *See* App. I, 30a, Sec. 102(a). Therefore, what defendants seek - immunity from objectively unreasonable actions on plaintiff's privileges - is available to them if they acted in good faith, but they must seek it under Virginia law, not by having the courts of Virginia rewrite federal law to protect them.

A. The application of a deferential standard resulted in rulings that conflict with the decisions of federal appellate courts and the courts of last resort of other states.

The incorrect standard urged by defendants was applied by the trial court and resulted in rulings that conflict with the decisions of federal appellate courts and the courts of last resort of other States in several respects. For example, the MEC was required to conduct a reasonable investigation before recommending revocation of all of plaintiff's privileges for immunity to attach to that action. *Singh*, 308 F.3d at 39 (citing 42 U.S.C. § 11112(a)(2). Whatever else a reasonable investigation may require, all courts agree that it requires review of the medical records of the cases on which a summary suspension of privileges was based. *Singh*, 308 F.3d at 42; *Imperial*, 37 F.3d at 1029; *Manzetti*, 776 A.2d at 943. The trial court ruled otherwise in this case because under the deferential standard it applied everything peer reviewers do is deemed reasonable.

In *Singh*, 308 F.3d at 42, the First Circuit rejected the contention that defendants had not conducted an adequate investigation precisely because members of

the Remedial Action Committee, who investigated plaintiff, independently reviewed several of the medical records on which the external reviewer's report was based, and did not simply rely on the external reviewer's report. In *Imperial*, 37 F.3d at 1029, the Fourth Circuit emphasized that the Credentials and Executive Committees had independently reviewed the plaintiff's competence, and each committee had independently determined that plaintiff should not be reappointed. Both these committee reviewed the medical records of several of plaintiff's cases to make their determination about reappointment. *See Imperial v. Suburban Hosp. Ass'n, Inc.*, 862 F.Supp. 1390, 1393-94 (D.Md. 1993).

In *Manzetti*, 776 A.2d at 943, the Supreme Court of Pennsylvania rejected plaintiff's specific challenge to the adequacy of the hospital's investigation by noting that after the Medical Executive Committee summarily suspended plaintiff's privileges to perform open heart surgeries, it decided to conduct further investigation into the matter and reconvene three weeks later. During this investigation the MEC "examined the medical records of more than a score of [plaintiff's] open-heart cases...[and] conducted interviews with eight anesthesiologists who had worked with Manzetti during open-heart surgeries".

In the only decided case that is at all analogous to the present one, the committees investigating a physician's practice did not review the medical records of his patients but relied on summaries contained in the report of an external reviewer, as in this case. *See Clermont v. Fallon Clinic*, No. 2001-1512B, 1998 Mass. Super. LEXIS 738 at *20-24 (Mass. Super. Ct. May 15,

2003). The Superior Court of Massachusetts, relying on the First Circuit's decision in *Singh* and the district court's decision in *Imperial*, held that a reasonable jury could conclude that the investigation preceding the peer review actions was obviously insufficient and, therefore, unreasonable. *Id.*[11]

In this case, the ad hoc committee relied on information provided to it by others, accepted the information at face value, and much of what the committee relied on was factually incorrect, fabricated or contrived.[12] Finding an investigation reasonable where reliance was placed on documents that contained numerous fabrications, false statements and contrived incidents is also inconsistent with the position of other appellate courts that "fabricating damaging incidents or purposeful overreacting would be conduct that no reasonable medical practitioner or

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[11] In this case, the investigation was even less reasonable than in *Clermont* in that the medical records sent to the external reviewer were incomplete. App. M, 44a, ¶ 8.

[12] For example, the "recent" laparoscopic complication used to justify plaintiff's suspension at Riverside occurred at the surgery center (a different legal entity at the time), and plaintiff's management of the case had already been determined to have been appropriate. *See* App. P, 52a, ¶ 2-53a, ¶ 1; *see also id.*, 54a, ¶ 1 (cases used to justify suspension changed during the investigation); *id.*, 53a, ¶ 3 (after the fact entries made in the medical records by nurses). One of the two cases used to justify imposing a proctorship of plaintiff's laparoscopic cases was treated seven months earlier and was determined to have been appropriately managed in the ordinary course of peer review. Criticisms were then fabricated about this case.

hospital could believe to be part of legitimate peer review". *See Boczar v. Manatee Hosp. & Health Sys. Inc.*, 993 F.2d 1514, 1518 (11th Cir. 1993); *accord Meyer*, 22 P.3d at 1151 ("There is no evidence or allegation that the doctors who evaluated Meyer's performance... were *manufacturing* or *exaggerating* facts to support disciplinary sanctions").

Even accepting, *arguendo*, that some corrective action on plaintiff's laparoscopic privileges was warranted, the holding that it was reasonable to suspend, and to recommend revoking, all of plaintiff's clinical privileges conflicts with decisions of federal circuit courts and other state courts of last resort holding that the action must be tailored to the concerns raised. In *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 638 (3d Cir. 1996), the hospital suspended the privileges of an orthopedic surgeon to perform spine surgery, and the court concluded that

> Because these restrictions were tailored to address the health care concerns raised...we believe the evidence supports the conclusion that the restrictions were imposed based on a reasonable belief that they were warranted by the facts known".

Id.; *accord Manzetti*, 776 A.2d at 943 (plaintiff, a cardiac surgeon with privileges "to perform all types of open heart and vascular surgical procedures", had his cardiac surgical privileges suspended after concerns were raised about his cardiac surgical skills and experience, but not his vascular surgical privileges).

In this case, the criticisms of plaintiff were confined to his endoscopic surgical practice, and laparoscopic cases in particular. The suspension in 1998 involved endoscopic cases and only laparoscopic cases were proctored. The cases that triggered the 2000 suspension all involved endoscopic procedures. The ad hoc committee that investigated the 2000 suspension expressly stated in its report that it drew no conclusions about plaintiff's obstetrical and non-laparoscopic surgical practice. Never the less, the hospital summarily suspended all of plaintiff's clinical privileges and the MEC later recommended that they all be revoked without any factual basis that suspension or revocation of plaintiff's obstetrical or non-endoscopic surgical privileges would further health care and protect patients. *See Mahmoodian*, 404 S.E.2d at 761 ("the potential effect on patient care may not be presumed but must be shown by the evidence").

III. THE STATE COURTS APPLIED AN INCORRECT STANDARD UNDER 42 U.S.C. § 11113 AND THEIR AWARD OF ATTORNEY'S FEES CONFLICTS WITH DECISION OF FEDERAL APPELLATE COURTS AND THIS COURT'S PRECEDENT.

The cost shifting provision of 42 U.S.C. § 11113 was drafted in language taken directly from the National Cooperative Research Act of 1984, 15 U.S.C. § 4303. *See* 132 Cong. Rec. H 11591 (daily ed. October 17, 1986) (statements of Rep. Waxman). That language was in turn based on the cost shifting provision of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-

5(k). *See* Scott, supra at 338-39 (1991). Therefore, an award of attorneys fees under 42 U.S.C. § 11113 is reviewed "in the same manner as [the court] review[s] the award of attorney fees under Title VII and 42 U.S.C . § 1988". *Muzquiz v. Foote Memorial Hosp.*, 70 F.3d 422, 431-32 (6th Cir. 1995). In the context of a claim for attorney's fees under Title VII, this Court has said that an award of attorney's fees is not appropriate where the defendant prevails on a case of first impression requiring judicial resolution. *See Christiansburg Garment Co. v. EEOC,* 434 U.S. 412, 423-24 (1978); *accord Sugarbaker v. SSM Health Care*, 187 F.3d 853, 857-58 (8th Cir. 1999) (hospital not entitled to attorney's fees, because no eighth circuit precedent addressed the standards for HCQIA immunity).

Before awarding attorney's fees to a prevailing defendant, the trial court must make factual findings that support a conclusion that the plaintiff's claim(s) or the conduct of the litigation were frivolous, unreasonable, without foundation or in bad faith, 42 U.S.C. § 11113; *Canady v. Providence Hosp.*, 1997 U.S. App. LEXIS 34885 (D.C. Cir. 1997), and the record must actually support such a conclusion, *Imperial v. Suburban Hosp. Ass'n*, 1998 U.S. App. LEXIS 893 at *3-6 (4th Cir. January 22, 1998) (unpublished opinion). In making factual findings to determine if plaintiff's claim was reasonable, this Court has admonished trial courts to resist the temptation to engage in *post hoc* reasoning and hindsight logic that would deter all but the most airtight claims. *See Christiansburg Garment Co.,* 434 U.S. at 421-22; *accord Mathews*, 87 F.3d 624 (important to avoid hindsight logic and conclude that because "plaintiff did not ultimately prevail, his action

must have been unreasonable or without foundation") (citing *Muzquiz*, 70 F.3d at 432).

In this case, the trial court held that plaintiff's claim was "unreasonable and without foundation brought" but made no factual findings to explain its rulings. *See* App. D, 11a, ¶ 2. What factual findings the court did make, do not support an award of attorney's fees because those findings - that false statements were made with reckless disregard of the truth - indicated that plaintiff's underlying claim for defamation was meritorious. *See Food Lion, Inc. v. Melton*, 458 S.E.2d 580, 584 (Va. 1995) (describing elements private plaintiff's must to prove to prevail on a claim for defamation). Moreover, defendants first asserted HCQIA immunity in their demurrer to the *Third Amended Motion for Judgment*, and the court overruled their demurrer to the defamation claim. It cannot be seriously contended that plaintiff should have dismissed his claim for defamation after the court overruled the demurrer to that claim.

There is no Virginia precedent involving HCQIA immunity and this Court has never considered the issue. There is no precedent from any jurisdiction holding peer review actions reasonable under 42 U.S.C. § 11112(a) where these were based on falsehoods and the court actually found that the record contained false statements made with reckless disregard. Nor is there any precedent for holding an investigation reasonable where the committee investigating a suspension failed to review the medical records of the cases on which the action was based. Therefore, plaintiff's challenge to defendants' immunity under 42 U.S.C. § 11111(a)(1) was one of

first impression for Virginia, and his position that defendants are not immune under 42 U.S.C. § 11111(a)(1) was based on facts in the record and case law from other jurisdictions.

The award of attorney's fees by the state courts in this case conflicts with the decision of every federal appellate court that has addressed the issue, and this Court's decision in *Christiansburg Garment Co.* It has given section 11113 an *in terrorem* effect inconsistent with the plain language of the statute and its legislative history. *See* App. I, 31a, Sec. 103 (the original fee shifting provision in H.R. 5110, rejected by Congress, allowed an award of attorney's fees to a prevailing defendant without any further showing). It will further shield improper peer review by discouraging legal challenges to unwarranted peer reviews actions.

IV. THE QUESTIONS PRESENTED ARE IMPORTANT.

Few matters are of greater concern to the general public and the medical profession, or affect them more directly, than the quality of medical care and its oversight. The adoption of legal standards that protect unwarranted peer review actions can be expected to have consequences that are inimical to high quality of care and defeat the very purpose for which HCQIA was enacted, as well destroy the careers of competent, conscientious physicians. *See Boczar*, 993 F.2d at 1518 n.10 (negative peer review actions can ruin a doctor's professional reputation and career).

First, it can be expected to encourage and entrench a discredited approach to peer review that seeks culprits to 'blame and shame' for adverse outcomes and errors rather than causes to remedy and barriers to erect to protects patients. *See e.g.* James Reason, *Human Error*, 320 BMJ 768 (2000), App. Q, 58a, ¶ 2 (stating that "continued adherence to the [persons approach] is likely to thwart the development of safer healthcare institutions").[13] The 'blame and shame' approach does not work because it fails to identify and correct latent failures in the health care environment that increase the uncertainty inherent in medical decisions and predispose to error. *Id.*, 59a, ¶ 1; Ownby at 18.

For example, the hysteroscopic complication at Riverside's surgery center that led to plaintiff's suspension in 1998 was related to fluid overload, and was preceded by two cases of fluid overload in the patients of other physicians. *See* App. P, 53a, ¶ 2. These prior cases were not reviewed, and the latent failures that led to these complications were not identified and corrected. *Id.* (stating that nurse felt procedures should not be done at surgery center). The committees investigating plaintiff also did not identify these deficiencies and were content to blame plaintiff. The deficiencies were eventually corrected only

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[13] *See also* Raymond L Ownby, *Medical Error Prevention*, at 12-14, available at http://www.med.miami.edu/med/education/cme/documents/OwnbyMedicalErrors_SelfInstructional2003_2.pdf (or by searching Google with the search term 'Ownby - medical error prevention')

because the hospital's own external reviewer identified them and urged their correction.[14]

Second, because physicians "who do procedures that are new or different" are often the target of pretextual peer review, *see* Note, 18 J. Contemp. Health L. & Pol'y at 252 (citation omitted), unwarranted peer review actions tend to chill legitimate minority opinions and deprive communities of expertise that would not otherwise be available locally. In this case, plaintiff engendered criticism because he was able to perform laparoscopic and other complex procedures his colleagues could not or would not do. Removing him from the medical staff removed an important resource for the local community. *See* App. R, 67a ("I was very happy that a local surgeon was willing to take on this very complex lady and certainly happy with your fine care"); App S, 69a (testimony of faculty member before hearing panel stating that the local community had "definitely lost an asset"). It also deprived other attendings and the residents of a valuable teaching resource. *See* App. T, 70a, ¶ 2 (attending physician stating that she had improved her proficiency in laparoscopic surgery and understanding of pelvic anatomy by having plaintiff assist her with difficult cases); *see also id.*, 71, ¶ 3 and

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[14] The latent failures were lack of fluid balance protocols and forms on which to record fluid balance, lack of closed-circuit system to measure fluid balance accurately, lack of equipment to measure electrolytes on the premises. A sentinel events inquiry ostensibly conducted by administration also failed to detect these systemic failures.

App. K, 36a-37a (describing plaintiff's influence on the surgical training of residents).[15]

No system of peer review can be error free. Congress has chosen to provide federal protection to peer review that meets certain criteria to encourage effective peer review. *See* 42 U.S.C. § 11112(a); App. H, 23a. Those criteria implicitly strike a balance between erroneously disciplining physicians who should not have been disciplined (false positive or type II error) and erroneously failing to discipline physicians who should have been disciplined (false negative or type I error). Reasonable people may differ over how false positive and false negative errors in peer review should be balanced, except that no reasonable person can believe that fabrications and contrived criticisms will further health care. *See Boczar*, 993 F.2d at 1518. It is also for Congress, not the courts, to determine where the balance should lie.

Congress enacted standards of objective reasonableness and required proof by the preponderance of the evidence to rebut the presumption that a particular professional review action met these standards. *See* 42 U.S.C. § 11112(a); App. H, 23a. The Virginia Supreme Court has changed that balance by adopting a deferential standard that has no parameters, that is an alloy of state and federal law, and that immunizes actions based on falsehoods made with at least reckless disregard of falsity. Only

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[15] Subsequent to these events the entire teaching faculty left and Riverside's Ob-Gyn residency program has been placed back on probation.

this Court can overrule the standard the Virginia Supreme Court has adopted. It should, respectfully, do so because the standard adopted can be expected to undermine the purposes of the statute, protect abuses of peer review, and cause injustice to physicians without any offsetting benefits to the public.

CONCLUSION

For all the foregoing reasons, petitioner, Paul J. Meyers, M.D., respectfully asks this Court to issue a Writ of Certiorari to the Supreme Court of Virginia.

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APPENDIX

APPENDIX A

SUPREME COURT OF VIRGINIA

Record No. 070241
Circuit Court No. CL31394-EH

[Filed October 24, 2007]

Paul J. Meyers, M.D.,	)
Appellant,	)
	)
against	)
	)
Riverside Hospital, Inc., et al.,	)
Appellees.	)
	)

From the Circuit Court of the City of Newport News

Upon review of the record in this case and consideration of the argument submitted in support of and in opposition to the granting of an appeal, the Court is of opinion there is no reversible error in the judgment complained of. Accordingly, the Court refuses the petition for appeal.

Justice Lemons took no part in the consideration of this case.

A Copy,

Teste:

Patricia L. Harrington, Clerk

By: /s/
Deputy Clerk

APPENDIX B

JOHN E. CLARKSON
Retired Judge
FOURTH JUDICIAL CIRCUIT
909 Hanover Avenue
Norfolk, VA 23508

June 12, 2006

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RE: Myers v. Riverside Hospital, Inc., et al
Law No. 31394-EH

Gentleman:

I thank each of you for your most professional handling of this most important case.

In this law action first filed October 23, 2001, of *Paul J. Myers, M.D. v. Riverside Hospital, Inc., et al* alleging damages, I have reviewed the many briefs filed, the cases cited and the 100 exhibits filed with plaintiff's Motion for Reconsideration. I find, through able counsel, cases that are either helpful or decisive on the issues presented here. *Jenkins v. Meth. Hospital Dallas, Singh, M.D. v. Blue Cross and Blus Shield and Rose Fuste, M.D.* and *Tien L. Vanden Hoek, M.D. v. Riverside Healthcare Association, Inc.*, 29743-VC, Circuit Court for the City of Newport News, VA.

I have previously found, and again today find, from the pleadings, exhibits, briefs, records of other cases, and after reviewing plaintiff's Motion for Reconsideration, his brief supporting the Motion for Reconsideration with the attached 100 exhibits, that the process and standards for professional review of the defendant Hospital under the Health Care Quality Improvement Act ("HCQIA"), 42 VSC §11101, were reasonable and, therefore, under (a)(1) those that participated in or assisted with the peer review activity are immune from damages.

I further find that defendants made a reasonable effort to obtain the facts, the investigation was reasonable and that plaintiff did not rebut defendants' presumption of immunity under 42 VSCS § 1112(a) by a preponderance of the evidence. Further, I find no evidence from the pleadings, exhibits, or argument of

counsel, that any one providing information to the medical review body provided false information proving that such information was false. Much information received by the review body has been alleged as false by plaintiff, but I find no evidence that the person *knew* it was false or testified untruthfully. I find no evidence or allegation of where, when or relevance of any alleged to be false evidence *knowingly* given, only examples of "reckless disregard" or a difference of opinion as to very complicated medical procedures. Experts do disagree.

Plaintiff's Motion for Partial Summary Judgment, with Motion for Sanctions, is denied.

Plaintiff's Motion for Reconsideration is denied.

Defendant's Demurrer to the Plaintiff's Third Amended Motion for Judgment is sustained, with no further leave to amend, dismissing this action with prejudice.

I ask Mr. Harris to prepare a sketch of an order, noting any objections, and after proper endorsement by all counsel, send to the Court for entry. The only issue remaining is defendants' Motion under § 11113 for payment of reasonable attorneys' fees and costs in defense of suit. This may be briefed and/or set for further hearing at a date convenient to Court and counsel.

Respectfully,
/s/
John E. Clarkson
Judge Designate

APPENDIX C

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[Filed September 15, 2006]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., *et al.*, Defendants.	)

ORDER

On April 20, 2006, the parties, by counsel, appeared before this Court to present oral argument on the following motions:

- Defendants' Motion for Reconsideration of Demurrer;
- Plaintiff's Motion for Partial Summary Judgment;
- Defendants' Motion for Sanctions;

- Defendants' Motions for Protective Order; and

- Plaintiff's Motions to Compel.

At the hearing, the Court denied Plaintiff's Motion for Partial Summary Judgment and Defendants' Motion for Sanction on the same. The Court granted the Plaintiff's oral motion to file a written motion to reconsider the ruling on the Demurrer reflected in the Order entered on August 16, 2005, holding that the Defendants' actions complied with the statutory standards under the Health Care Quality Improvement Act and that the Plaintiff had failed to rebut the Defendants' presumption of immunity by a preponderance of the evidence but overruling the Demurrer, holding that the Plaintiff had alleged that the Defendants had knowingly made false statements, and if that was true, they lost all immunity. The Court Ordered the Plaintiff to submit a brief within 30 days and the Defendants to submit an answer within 30 days of the Plaintiff's brief. Because the Defendants' Motion for Reconsideration could dispose of discovery, the Court held in abeyance the parties' respective Motions relating to discovery. The Court took the Defendants' Motion for Reconsideration under advisement.

After considering the briefs and arguments of counsel, the Court grants the Defendants' Motion for the reasons stated in the Court's letter Opinion dated June 12, 2006, which is incorporated by reference into this Order. After considering the brief submitted by the Plaintiff, the Court denies the Plaintiff's Motion for

Reconsideration of the Court's ORDER on August 16, 2005. The Court sustains the Demurrer and denies the Plaintiff any further leave to amend.

This action shall remain on the active docket for consideration of an award of reasonable attorney's fees and costs to the Defendants pursuant to 42 U.S.C. § 11113.

The Court directs the Clerk of Court to send a *teste* copy of this Order to counsel of record.

ENTER: Sept./ 15 / 2006

/s/
Judge John E. Clarkson, Judge Designate

Seen and agreed to regarding the Court's (1) granting the Defendants' Motion for Reconsideration, (2) sustaining the Demurrer, (3) denying Plaintiff's Motion for Reconsideration, and (4) denying Plaintiff's Motion for Partial Summary Judgment, but objecting to the Court's denying the Defendants' Motion for Sanctions:

/s/
Robert L. Harris, Jr., Esquire (VSB 33454)
LeClair Ryan, A Professional Corporation
The Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Post Office Box 2499
Richmond, Virginia 23218-2499

Telephone: (804) 545-1505
Facsimile: (804) 545-1501

Counsel for the Defendants

Seen and objected to:

/s/_____
Terrence K. Martin, Esquire (VSB 06845)
714 J. Clyde Morris Boulevard
Newport News, Virginia 23607
Telephone: (757) 599-9822
Facsimile: (757) 599-9824

Nicholas Kadar, M.D., J.D., LLM
11 Jackson Court
Cranbury, New Jersey 08512
Telephone: (609) 655-2459
Facsimile: (609) 395-9514

Counsel for the Plaintiff

APPENDIX D

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394-EH

[September 15, 2006]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, *et al.*,
Defendants.

BEFORE: The Honorable John E. Clarkson, Judge

DATE: September 15, 2006

APPEARANCES: NICHOLAS KADAR, ESQ.
11 Jackson Court
Cranbury, New Jersey 08512
- and -
TERRENCE K. MARTIN, ESQ.
714 J. Clyde Morris Boulevard
Newport News, 23501-1500

Counsel on behalf of the Plaintiff

ROBERT L. HARRIS, JR., ESQ.
ALLEN & ALLEN
Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Richmond, Virginia 23219
Counsel on behalf of Defendant
Riverside

Reported by: Victoria L. DeBerry

[p.86]

Defendants' Exhibit 2.

(Whereupon, Defendants' Exhibit Nos. 1 and 2 were marked and received into evidence.)

THE COURT: I have entered the order that was presented to me today. I've entered it September 15,2006. It's been endorsed. I think each of you have objected to something. But anyway, I've entered that.

Now, as to an order for today, first of all, I'm going to find that this cause was unreasonable and without foundation brought, and I'm going to award costs and attorney's fees.

Now, as to costs, they'll be all taxable court costs and deposition and court reporter costs. And attorney's fees I find are reasonable that you have given to me, Mr. Harris. But I am going to start that, in other

* * *

APPENDIX E

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[Filed October 31, 2006]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., *et al.*, Defendants.	)

FINAL ORDER

THIS DAY CAME the parties, by counsel, upon the Defendants' *Motion for Attorneys' Fees*. The Court has reviewed the parties' respective Memoranda of Law regarding the reasonableness of the fees and costs incurred by the Defendants, as well as the propriety of Dr. Meyers' filing and pursuing this action. The Court notes preliminarily that Dr. Meyers does not contest the reasonableness of the Defendants' fees and costs. Having considered the parties' respective positions and the arguments of their counsel, the Court finds that Dr. Meyers' conduct in this litigation has been

unreasonable. For the period beginning April 10, 2003, and concluding on April 20, 2006, the Court awards the Defendants attorneys' fees in the amount of $91,016. The Court also awards the Defendants court costs in the amount of $1,268.48. Having made these rulings, the Court enters judgment against Dr. Meyers in the sum of $92,284.48, with interest accruing at the judgment rate from the date of judgment until payment in full.

The parties' objections lodged in all previous orders are preserved.

Having disposed of all issues, the Court dismisses this action with prejudice and requests the Clerk of Courts to place it among the ended causes.

ENTER: Oct / 31 / 06

/s/
Judge John Clarkson

The Defendants ask for the award of attorneys' fees and costs but object to the amount awarded:

/s/
Robert L. Harris, Jr., Esquire (VSB 33454)
LECLAIR RYAN, A Professional Corporation
The Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Post Office Box 2499
Richmond, Virginia 23218-2499
Telephone: (804) 545-1505
Facsimile: (804) 545-1501

Seen and objected to for the reasons stated in the record:

/s/_____
Terrence K. Martin, Esquire
714 J. Clyde Morris Boulevard, Suite 140
Newport News, Virginia 23601

Nicholas Kadar, M.D., J.D.
11 Jackson Court
Cranbury, New Jersey 08512

APPENDIX F

July 27,2005

Nicholas Kadar, M.D., Esq.
11 Jackson Court
Cranbury, New Jersey 08512

Robert L. Harris, Jr., Esq.
LeClair Ryan
P. O. Box 2499
Richmond, Virginia 23218-2499

Paul J. Meyers, M.D. v. Riverside Hospital, *et al.*
At Law No. 31394-EH

Dear Counsel:

This law action is now before this Court on Defendants' demurrer to Meyers Third Amended Motion for Judgment.

Plaintiff alleges defamation (multiple counts) in Count I (264-302), tortuous interference with contract expectancy in Count II (303-319) and seeks monetary damages.

Defendants demur citing in part Health Care Quality Improvement Act, 42 U.S.C. § 11101 ("HCQIA") which immunizes the participants in the peer review process from liability "in damages under

any law of the United States or any State" if the peer review "meets all the standards specified in § 1112(a) of this title 42 U.S.C. § 111(a).

I find from the exhibits and argument of counsel that the standards for professional review actions have been fulfilled. The standards necessary for protection have not been rebutted by a preponderance of the evidence.

The issue now presents in 42 U.S.C. § 1111(a)(2) as plaintiff *alleges* person or persons providing information to the review body gave false information "and the persons providing it knew that such information was false". If true, the defendants' lose all immunity under "HCQIA".

As to Count I, the demurrer is overruled.

As to Count II, the demurrer is sustained and dismissed without leave to amend for reasons previously stated in that sufficient facts to state a cause of action have not been pled.

I request Nicholas Kadar, M.D., Esq. to prepare an order consistent with this opinion and after endorsement by counsel, forward to me for entry.

I am most appreciative of your extensive "briefing" and professional handling of this action.

Respectfully yours,
/s/
John E. Clarkson
Retired Judge

APPENDIX G

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[Filed August 16, 2005]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., et al., Defendants.	)

ORDER

THIS MATTER came before the Court on the Defendants' Demurrer to the Plaintiff's Third Amended Motion for Judgment for Defamation (Count I) and Tortious Interference with Contract Expectancy (Count II) and Motion Craving Oyer. The Motions were argued by counsel for the Plaintiff and the Defendants on June 23, 2005, and the parties were granted leave to submit further briefs. Having considered the Plaintiff's Third Amended Motion for Judgment, the briefs submitted by the parties, and the arguments of their counsel, it is accordingly

ADJUDGED and ORDERED that

(a) Defendants' Motion Craving Oyer is GRANTED with leave to append Plaintiff's Exhibits 58-67 attached to the Plaintiff's brief opposing the Motion;

(b) The Demurrer to Count I of the Third Amended Motion for Judgment for Defamation is OVERRULED;

(c) The Demurrer to Count II of the Third Amended Motion for Judgment for Tortious Interference with Contract Expectancy is SUSTAINED without leave to amend.

(d) The Defendants shall answer the Third Amended Motion for Judgment within 21 days after the date the Clerk of Court mails a copy of this Order to counsel of record.

Noting that Dr. Meyers has not named Urology of Virginia, Inc. in the *Third Amended Motion for Judgment* and that Dr. Meyers has requested the dismissal of that defendant with prejudice, the Court DISMISSES WITH PREJUDICE this action with respect to Urology of Virginia, Inc.

The Court directs the Clerk of Court to send a teste copy of this Order to counsel of record.

ENTER: 8 / 16 / 5

/s/
The Honorable John E. Clarkson

Seen and agreed to regarding all matters save the holding that the Defendants' actions complied with the statutory standards under the Health Care Quality Improvement Act

/s/

Nicholas Kadar,
11 Jackson Court
Cranbury, New Jersey 08512
Telephone: (609) 655-2459
Fax: (609) 395-9514

Terrence K. Martin
714 J. Clyde Morns Boulevard, Suite 140
Newport News, Virginia 23601
(757) 599-9822
(757) 599-9824 (fax)

Counsel for Plaintiff

Seen and agreed to regarding dismissal of Urology of Virginia, Inc., and the rulings on the Motion Craving Oyer and the Demurrer to Count II but objected to the granting of leave to Dr. Meyers to include more exhibits on Demurrer and the overruling of the Demurrer to Count I:

/s/

Everette G. Allen, Jr. (VSB #05197)
Robert L. Harris, Jr. (VSB #33454)
LECLAIR RYAN, A PROFESSIONAL CORPORATION
Federal Reserve Bank Building

APPENDIX H

TITLE 42 – THE PUBLIC HEALTH AND WELFARE
CHAPTER 117 – ENCOURAGING GOOD FAITH PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11101. Findings

The Congress finds the following:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from

participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

SUBCHAPTER I – PROMOTION OF PROFESSIONAL REVIEW ACTIVITIES

42 U.S.C. § 11111. Professional review

(a) In general

(1) Limitation on damages for professional review actions

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section –

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action,

shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964,42 U.S.C. § 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. § 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of title 15, where such an action is otherwise authorized.

(2) Protection for those providing information to professional review bodies

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

* * *

42 U.S.C. § 11112. Standards for professional review actions

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

* * *

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as –

(1) requiring the procedures referred to in subsection (a)(3) of this section –

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

42 U.S.C. § 11113. Payment of reasonable attorneys' fees and costs in defense of suit

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112(a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a

reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unseasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

42 U.S.C. § 11115. Construction

(a) In general

Except as specifically provided in this subchapter, nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities. or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter.

* * *

42 U.S.C. § 11151. Definitions

In this chapter:

(1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity

* * *

(4)(A) The term "health care entity" means –

(i) a hospital that is licensed to provide health care services by the State in which it is located,

* * *

(8) The term "physician" means a doctor of medicine or osteopathy. . . legally authorized to practice medicine and surgery. . . by a State. . .

(9) The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on –

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term "professional review activity" means an activity of a health care entity with respect to an individual physician –

(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,

(B) to determine the scope or conditions of such privileges or membership, or

(C) to change or modify such privileges or membership.

(11) The term "professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

APPENDIX I

99th CONGRESS
2D SESSION

H.R. 5110

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES
June 26, 1986

MR. WYDEN (for himself, MR. WAXMAN, MR. MADIGAN, and MR. TAUKE) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE

This Act may be cited as the "Health Care Quality Improvement Act of 1986".

* * *

SEC. 102. STANDARDS FOR A PROFESSIONAL REVIEW BODY.

(a) IN GENERAL.—The standards of this subsection, with respect to a professional review action, are that the action is taken—

(1) in good faith in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate due process to the physician or other licensed health care practitioner involved, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after the due process described in paragraph (3).

A professional review action is presumed to have been taken in good faith in the furtherance of quality health

care unless it is shown, by clear and convincing evidence, to the contrary.

* * *

SEC. 103. PAYMENT OF REASONABLE ATTORNEYS' FEES AND COSTS IN DEFENSE OF SUIT.

In any suit brought against a defendant, to the extent that section 101 applies with respect to the defendant and the defendant substantially prevails, the defendant shall be entitled to recover from the plaintiff reasonable attorneys' fees plus costs in defense of the suit.

APPENDIX J

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31395-EH

[April 20, 2006]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, et al.
Defendants.

BEFORE: The Honorable John E. Clarkson, Judge

DATE: April 20, 2006

Reported by: Victoria L. DeBerry

[p.53]

documents in those files, documents in those files, and they're all immune for this because the hospital is

immune. That means from now on, they can publish and say about this man beloved by the residents that he asked a nurse to alter a clinical trial variance. If this Court believes that Congress intended that, I, with the deepest respect for the Court, disagree with that. Congress could not possibly have ever intended that. Thank you.

MR. HARRIS: May I have a brief rebuttal, Your Honor?

THE COURT: You certainly may.

MR. HARRIS: Judge, I thought for a few minutes there we were hearing argument on the facts. This case is in a posture from a legal standpoint at which part of HCQIA applies. If Your Honor gets into examining the facts again, Your Honor is doing expressly what Congress and the courts uniformly have said, and that is we're not here to substitute our judgment for that of the hospital body. In fact, Your Honor said two years ago that I'm not going to second-guess the doctors, and I have a transcript of it. But you granted leave to amend. If due process is afforded through an administrative action that satisfies HCQIA, then that's what you're entitled to and immunity flows from that.

The Virginia Supreme Court said, thank you, that we tried -- our goal is to reconcile provisions to

[p.60]

case against one of its administrators.

So, Your Honor, Judge Conway decided this case I'd say close to the last minute. I'm asking Your Honor to reconsider this in light of what we advanced before, but also in light of what we've advanced since.

And I think Dr. Kadar said that I hadn't explained why I didn't bring up the *Jenkins* case before. I thought it was the first thing I said, was that it was my fault I didn't find it, shame on me, I wish I had found it sooner, I wish I had conversed with counsel here, maybe we could have colluded and conspired on this legal argument. I'd be maybe a defendant in a case coming forward, who knows. But I ask Your Honor to reconsider the demurrer, to sustain it and dismiss the action with prejudice.

THE COURT: I'll certainly reconsider.

DR. KADAR: May I make a motion, because I think I forgot the other point, Your Honor, because Your Honor was away? I read the rules, and you need the Court's permission to file a brief more than 20 pages, and I would like the Court's permission to file a motion for reconsideration of Riverside's immunity based on the evidence that we have acquired through discovery to show that they did not satisfy the requirement of (a)(2) and (a)(4), and I would like permission to file it, because obviously I can't cover that in a brief less than 20 pages.

[p.61]

THE COURT: All right, counsel, I would like to get this case going somewhere.

DR. KADAR: We do too, Your Honor. Can I just say that we are in fact --

THE COURT: Do you want to file some motions?

DR. KADAR: Well, I mean --

THE COURT: Let's get all the filings in and then I'm going to ask that the record be typed up. You all know this case so much better than I'll ever know it, so I want to take advantage of what you've said to me today. Why don't you take ten days to file whatever you want.

DR. KADAR: Your Honor, can I throw myself at the mercy of the Court. I've just been bombarded with briefs from Yale, so can I --

THE COURT: You can have all the time you want. How much time do you want?

DR. KADAR: I'll do it within, for sure, three weeks. I'll try and do it before.

THE COURT: I'll give you a month, I'll give you a month.

MR. HARRIS: Your Honor, let me --

THE COURT: Get the record typed up, and then I'm going to come over here and spend a couple of days and I'm going to read it all and I'll write an opinion.

APPENDIX K

July 1 , 2000

RE: Paul Meyers, MD

Dear Dr. Kauder,

I am writing to you in support of Dr. Paul Meyers. I have known him over my five years of training here at Riverside. I have found him an extremely valuable asset in terms of my training, and to the residency program as a whole. In particular, he has provided me with a breadth and depth in laparoscopic procedures that I doubt I would find at any other program in Virginia. Collectively, as residents, we have sought him out to perform our most challenging laparoscopic cases, like those involving abcesses, large benign pelvic masses, and endoscopic suturing. He has always exercised extreme caution when proceeding in such cases and in even in spite of that, encountered complications, which were more a result of the pathology involved, rather than his skill or technique. He has also shown an uncanny ability to recognize those complications, and manage them laparoscopically when possible, and conventionally when appropriate. He has given me the opportunity to exercise discretion in the management of my cases in a controlled environment. This has been crucial to my training as a gynecologist. I think I speak for most if not all resident when I say that the training program will miss his skill and guidance.

Sincerely,

/s/
Michael Seryakov, M.D.

JUDITH A. GURDIAN, M.D. AND ASSOCIATES, P.D.
OBSTETRICS AND GYNECOLOGY
1500 RESEARCH BOULEVARD, SUITE 100
ROCKVILLE, MD 20850

Judith A. Gurdian, M.D.
Steve Behram, M.D.
Patricia E. Shevock, P.A.-C.

Bruce Kauder, M.D.
Medical Staff President
Riverside Regional Medical Center
500 J. Clyde Morris Blvd
Newport News, V A 23601

July 10, 2000

Dear Dr. Kauder,

This letter is to me as a letter of reference on behalf of Dr. Paul J. Meyers. I have known Dr. Meyers during all the phases my of training and practice; beginning as a third-year medical student in 1993, as a fourth-year medical student in 1994, as an OB/GYN resident from 1994 through 1998, and as a faculty member and professional colleague from 1998 to the current time. As such, I hope that my perspective may be of value to you and your colleagues in your evaluation of Dr. Meyers.

Under the instruction of Dr. Meyers, I was able to develop an extensive array of advanced laparoscopy skills that would otherwise not have been possible at Riverside Hospital. Dr. Meyers has been the only faculty member offering laparoscopic Burch training

among other complicated pelviscopic procedures. As residents, we would commonly post our most complicated and surgically demanding laparoscopic cases with Dr. Meyers. In fact, I continued to operate with Dr. Meyers on my most complicated cases in the private setting because of his extensive experience in this particular field.

During my years with Dr. Meyers I have always known him to act in a professional and ethical matter. He has consistently demonstrated excellent decision-making skills during the cases that we have shared over the years, His departure from residency training program will create a significant educational deficit which will be very difficult to overcome. His potential loss from the community will forever deprive the region of this skilled physician and surgeon.

Cordially,
/s/
Steve Behram. M.D.

cc: Rudolph Freeman, M.D.
Paul J. Meyers, M.D.

APPENDIX L

RIVERSIDE
HAMPTON ROADS GYN ONCOLOGY

To: Karen Bruder, MD FACOG, Chairman of the Department of Obstetrics and Gynecology, Riverside Regional Medical Center

From: William J Mann, Jr MD FACOG FACS MBA

September 19, 1999

Re: Mentorship of Paul Meyers, MD FACOG

I have completed the mentorship of Dr. Paul Meyers' endoscopic surgery at Riverside Regional Medical Center, and am writing this memo in response to a request for it from Dr. Bruder and Freeman. A one page form, provided by Dr. Freeman, was filled out for each case and returned to Dr. Freeman. No entrees were made in the medical record, and no copy of this form was added to any medical record, in accordance with Dr. Freeman's instructions to me.

I have reviewed with Dr. Meyers the indication for surgery in each case, and without exception I found that the proposed procedures were indicated and appropriate, and that patient selection was sound.

I have also reviewed the medical records for each patient, discussed the pre-operative patient

preparation for each case, and again found without exception that appropriate pre-operative patient care had been administered.

I directly observed all the operative procedures in the operating suite, and in every instance, the surgical skills evidenced by Dr. Meyers were excellent. In fact, he may very well be the most accomplished laparoscopic surgeon at our medical center, and certainly is the most experienced in the use of endoscopic techniques for pelvic floor reconstruction.

In each case, I confirmed that informed consent had been obtained and was properly documented, and that each and every records was complete and accurate. The medical records were very complete.

I discussed the post-operative care with Dr. Meyers and with the OB/GYN housestaff for each patient, and found the post-operative care to be appropriate and reasonable. The patient outcomes were uniformly very good.

During the mentorship, I also noted that several attending physicians (Dr. Thom, Dr. Tim O'Connel, Dr. Coyle, Dr. Behram) as well as myself, requested Dr. Meyers opinion with respect to the endoscopic management of specific private patients. I believe this demonstrates recognition by attending physicians in Obstetrics and Gynecology of Dr. Meyers' exceptional expertise in endoscopic surgery.

In my opinion, Dr. Meyers is a competent and talented endoscopic surgeon, and is a valuable part of our local medical community. I have never understood why his

privileges were restricted, as the apparent result of his having experienced recognized and accepted surgical complications, which were appropriately managed, but I believe my period of close observation of his endoscopic skills confirms what a significant proportion of the gynecologic community already recognizes, namely that he is a competent, skilled gynecologic endoscopist. Indeed, our medical community could profit considerably from Dr. Meyers sharing his skills with his colleagues, something he willingly does.

APPENDIX M

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394EH

[May 19, 2003]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., et al.,
Defendants.

DEPOSITION OF CARL J. LEVINSON
May 19, 2003

[p.226]

Q. Well, I don't have the nurse's notes.

A. - - because they say the only complaint was dysuria.

Q. On the 13th when she came back?

A. How about the admitting note?

Q. Well, Doctor - -

A. No. I'm trying to point out that if she had sudden abdominal pain - -

Q. You wouldn't be critical?

A. I wouldn't have been critical.

Q. But you could have called up, couldn't you?

A. I could have called up on every case.

Q. Well, you didn't have in every case deficient operative notes? You didn't have absent operative notes on every case, did you?

A. No. I had a lot of things missing on almost every case. Do you have that nurse's admitting note?

* * *

[p.275]

send you copies. It's just so I remember what it is.

A. I'm wondering if I looked at her pathology report at all, because the questionable secretory endometrium, some evidence of adenomyosis and one small myoma just doesn't exist for this patient.

BY MR. KADAR:

Q. Knowing what we know now, would you perhaps revise your opinion that the indications were questionable in this patient?

A. Yes, there were good indications for surgery.

* * *

APPENDIX N

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31395-EH

[April 9, 2003]

PAUL J. MEYERS, M.D.,
Plaintiff,

v.

RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, et al.
Defendants.

BEFORE: The Honorable John E. Clarkson, Judge

DATE: April 9, 2003

APPEARANCES: NICHOLAS KADAR, ESQ.
11 Jackson Court
Cranbury, New Jersey 08512
- and -
TERRENCE K. MARTIN, ESQ.
714 J. Clyde Morris Boulevard

Newport News, 23501-1500
Counsel on behalf of the Plaintiff

ROBERT L. HARRIS, JR., ESQ.
ALLEN & ALLEN
Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Richmond, Virginia 23219
Counsel on behalf of Defendant
Riverside

KRISTAN B. BURCH, ESQ.
Kaufman & Canoles
150 West Main Street, Suite 2100
Norfolk, Virginia 23510-1609
Counsel on behalf of Defendant
Partridge

Reported by: Victoria L. DeBerry

[p.158]

THE COURT: There shouldn't be a problem.

DR. KADAR: I agree, I agree. I thought we would say yes, these are authentic and that would be it, and it was much to my amazement everybody --

THE COURT: Okay. We'll get to that. If there is a problem, we'll get to it early.

MR. HARRIS: Thank you, Judge.

DR. KADAR: Judge, I am conscious that we have exasperated you, and I thank you for your --

THE COURT: No, you haven't exasperated me, not yet. We'll get there. You-all are spending an awful lot of time --

DR. KADAR: But it's very important, Your Honor. This man's entire career is at stake here.

THE COURT: But I can't -- I have a hard time believing that a group of doctors are so evil.

DR. KADAR: Well, you see, this is what is of major --

THE COURT: A lot of my good friends are doctors. Maybe there's no guilt by association.

DR. KADAR: This is what is of major concern to me, this cannot be decided on one's experience of doctors.

THE COURT: Most doctors are A students, most lawyers are B students. Every time I go to a doctor,

[p.159]

I'm so thankful they were so smart. And you know, most doctors -- I don't know of a bad doctor, and I've been trying cases for over 40 years. I may not agree with doctors and doctors don't agree with themselves, every medical malpractice case I get, there's going to be two sides and they're both positive, but I don't know of any evil doctors that are going to gang up on -- I mean, I look at him and he looks like an awful nice guy

* * *

APPENDIX O

CIRCUIT COURT FOR THE CITY OF NEWPORT NEWS, VIRGINIA

No. 31394-EH

[June 23, 2005]

PAUL J. MEYERS, M.D., Plaintiff,	)
v.	)
RIVERSIDE HOSPITAL, INC., t/a RIVERSIDE REGIONAL MEDICAL CENTER, et al. Defendants.	)

BEFORE: The Honorable John E. Clarkson, Judge

DATE: June 23, 2005

APPEARANCES: NICHOLAS KADAR, ESQ.
11 Jackson Court
Cranbury, New Jersey 08512
- and -
TERRENCE K. MARTIN, ESQ.
714 J. Clyde Morris Boulevard

Newport News, 23501-1500
Counsel on behalf of the Plaintiff

ROBERT L. HARRIS, JR., ESQ.
ALLEN & ALLEN
Federal Reserve Bank Building
701 East Byrd Street, 16th Floor
Richmond, Virginia 23219
Counsel on behalf of Defendant Riverside

Reported by: Victoria L. DeBerry

[p.89]

best I can do.

MR. HARRIS: That's fine.

THE COURT: What worries me, quite frankly, is it's on a demurrer. If it was a motion for summary judgment, it would be easy, but on a demurrer -- that's what I'm worried about.

MR. HARRIS: All we can ask is if you look at the entire --

THE COURT: I'll look at it.

MR. HARRIS: Thank you, Your Honor.

THE COURT: I think he may have -- may be staying in court, maybe. Okay.

DR. KADAR: Thank you, Your Honor.

THE COURT: Can I take this along because I don't

DR. KADAR: Sure, sure you can, Your Honor.

THE COURT: I don't need the notebook.

MR. HARRIS: May I just see what it is?

THE COURT: I guess it's the statute. I'm worried about who makes the decision, as I've told you two or three times. You know, quite frankly, if I was to make it, I think they did everything reasonably, you know, reasonable, may not be perfect, but it's reasonable, but I'm not sure that I make that decision.

APPENDIX P

RIVERSIDE
REGIONAL MEDICAL CENTER

December 30, 1998

Dr. Rudolph Freeman
Vice President of Medical Affairs
Riverside Regional Medical Center
500 J. Clyde Morris Blvd.
Newport News, VA 23601

Dear Rudolph,

All of this business about Dr. Paul Meyers has brought to my attention again that we need to reevaluate our credentialing process at this institution. This is particularly obvious when the credentials are different between the main Medical Center and the Surgical Center. In addition, with the possible fusion with Mary Immaculate Hospital coming up in the next six to twelve weeks, consideration of a "pan" system for credentialing would be very appropriate.

Secondly, having a committee that is responsible for a review of cases at the Surgery Center that is different from the one here at the Medical Center creates confusion. In fact, Dr. Meyers has received a letter from that committee at the Surgery Center, stating that his management of the laparoscopic case in question was entirely appropriate. That would tend

to make the Executive Committee look like a group of bumpkins, since we are evaluating him, partially at least, based on that case.

Thirdly, as I mentioned at the Executive Committee meeting before Christmas, there has been two other cases of fluid overload by other members of the gynecologic surgery staff in the hysteroscopic procedure. While I was told there was a written policy and procedure concerning this procedure, I have yet to see it and, in fact, no one seems to be able to put their hands on it. Anecdotally, Dr. Mann tells me the OR nurses have been very concerned about his. In fact, this procedure is such that he and I wonder if it should not be done here at the Medical Center rather than scheduled for outpatient surgery because of its potential for high risk complications.

Fourthly, I spoke with Mr. Brink recently about some changes in the medical record that occurred after the patient that Dr. Meyers had cared for this hysteroscopy was transferred to the Medical Center. The record certainly does not look the same and it may be an entirely innocent situation, but on the other hand, if there were to be any liability claims from this case, it certainly would not look good if an attorney were to find out about the post dating of medical records. I have provided through Dr. Meyers a copy of the two different sheets of paper from the medical record and if I were a paranoid individual, I would certainly wonder if someone was "out to get me". At any rate, Mr. Brink has those records and I am sure will share them with you.

Please let me know what I can do to assist as we go through this process. I was pleased to learn that we have an expert who is now contracted to review all of the records that were in question. There is some question in my mind, however, that there is now a difference in the listing of the medical records that were presented to the Medical Executive Committee verses the one that is apparently being questioned and reviewed.

Very Truly Yours,

/s/

T. Eugene Temple, Jr., M.D.

APPENDIX Q

Education and debate

Human error: models and management
James Reason

Department of Psychology,
University of Manchester,
Manchester
M13 9PL
James Reason
professor of psychology
reason@psy.man.ac.uk

BMJ 2000;320:768–70

The human error problem can be viewed in two ways: the person approach and the system approach. Each has its model of error causation and each model gives rise to quite different philosophies of error management. Understanding these differences has important practical implications for coping with the ever present risk of mishaps in clinical practice.

Summary points

Two approaches to the problem of human fallibility exist: the person and the system approaches

The person approach focuses on the errors of individuals, blaming them for forgetfulness, inattention, or moral weakness

The system approach concentrates on the conditions under which individuals work and tries to build defences to avert errors or mitigate their effects

High reliability organisations—which have less than their fair share of accidents—recognise that human variability is a force to harness in averting errors, but they work hard to focus that variability and are constantly preoccupied with the possibility of failure

Person approach

The longstanding and widespread tradition of the person approach focuses on the unsafe acts—errors and procedural violations—of people at the sharp end: nurses, physicians, surgeons, anaesthetists, pharmacists, and the like. It views these unsafe acts as arising primarily from aberrant mental processes such as forgetfulness, inattention, poor motivation, carelessness, negligence, and recklessness. Naturally

enough, the associated countermeasures are directed mainly at reducing unwanted variability in human behaviour. These methods include poster campaigns that appeal to people's sense of fear, writing another procedure (or adding to existing ones), disciplinary measures, threat of litigation, retraining, naming, blaming, and shaming. Followers of this approach tend to treat errors as moral issues, assuming that bad things happen to bad people—what psychologists have called the just world hypothesis.[1]

System approach

The basic premise in the system approach is that humans are fallible and errors are to be expected, even in the best organisations. Errors are seen as consequences rather than causes, having their origins not so much in the perversity of human nature as in "upstream" systemic factors. These include recurrent error traps in the workplace and the organisational processes that give rise to them. Countermeasures are based on the assumption that though we cannot change the human condition, we can change the conditions under which humans work. A central idea is that of system defences. All hazardous technologies possess barriers and safeguards. When an adverse event occurs, the important issue is not who blundered, but how and why the defences failed.

Evaluating the person approach

The person approach remains the dominant tradition in medicine, as elsewhere. From some perspectives it has much to commend it. Blaming individuals is emotionally more satisfying than targeting

institutions. People are viewed as free agents capable of choosing between safe and unsafe modes of behaviour. If something goes wrong, it seems obvious that an individual (or group of individuals) must have been responsible. Seeking as far as possible to uncouple a person's unsafe acts from any institutional responsibility is clearly in the interests of managers. It is also legally more convenient, at least in Britain.

Nevertheless, the person approach has serious shortcomings and is ill suited to the medical domain. Indeed, continued adherence to this approach is likely to thwart the development of safer healthcare institutions.

Although some unsafe acts in any sphere are egregious, the vast majority are not. In aviation maintenance—a hands-on activity similar to medical practice in many respects—some 90% of quality lapses were judged as blameless.[2] Effective risk management depends crucially on establishing a reporting culture.[3] Without a detailed analysis of mishaps, incidents, near misses, and "free lessons," we have no way of uncovering recurrent error traps or of knowing where the "edge" is until we fall over it. The complete absence of such a reporting culture within the Soviet Union contributed crucially to the Chernobyl disaster.[4] Trust is a key element of a reporting culture and this, in turn, requires the existence of a just culture—one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions.[5] Engineering a just culture is an essential early step in creating a safe culture.

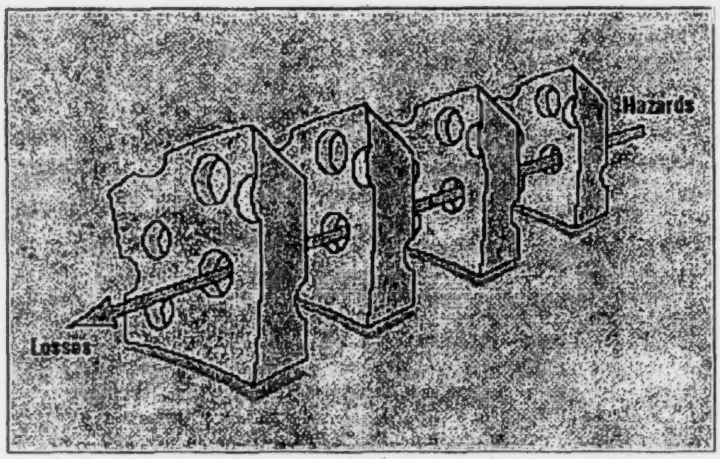
Another serious weakness of the person approach is that by focusing on the individual origins of error it isolates unsafe acts from their system context. As a result, two important features of human error tend to be overlooked. Firstly, it is often the best people who make the worst mistakes—error is not the monopoly of an unfortunate few. Secondly, far from being random, mishaps tend to fall into recurrent patterns. The same set of circumstances can provoke similar errors, regardless of the people involved. The pursuit of greater safety is seriously impeded by an approach that does not seek out and remove the error provoking properties within the system at large.

The Swiss cheese model of system accidents

Defences, barriers, and safeguards occupy a key position in the system approach. High technology systems have many defensive layers: some are engineered (alarms, physical barriers, automatic shutdowns, etc), others rely on people (surgeons, anaesthetists, pilots, control room operators, etc), and yet others depend on procedures and administrative controls. Their function is to protect potential victims and assets from local hazards. Mostly they do this very effectively, but there are always weaknesses.

In an ideal world each defensive layer would be intact. In reality, however, they are more like slices of Swiss cheese, having many holes—though unlike in the cheese, these holes are continually opening, shutting, and shifting their location. The presence of holes in any one "slice" does not normally cause a bad outcome. Usually, this can happen only when the holes in many layers momentarily line up to permit a

trajectory of accident opportunity—bringing hazards into damaging contact with victims (figure).



The Swiss cheese model of how defences, barriers, and safeguards may be penetrated by an accident trajectory

The holes in the defences arise for two reasons: active failures and latent conditions. Nearly all adverse events involve a combination of these two sets of factors.

Active failures are the unsafe acts committed by people who are in direct contact with the patient or system. They take a variety of forms: slips, lapses, fumbles, mistakes, and procedural violations.[6] Active failures have a direct and usually shortlived impact on the integrity of the defences. At Chernobyl, for example, the operators wrongly violated plant procedures and switched off successive safety systems, thus creating the immediate trigger for the catastrophic explosion in the core. Followers of the person approach often look no further for the causes of an adverse event once they have identified these

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proximal unsafe acts. But, as discussed below, virtually all such acts have a causal history that extends back in time and up through the levels of the system.

Latent conditions are the inevitable "resident pathogens" within the system. They arise from decisions made by designers, builders, procedure writers, and top level management. Such decisions may be mistaken, but they need not be. All such strategic decisions have the potential for introducing pathogens into the system. Latent conditions have two kinds of adverse effect: they can translate into error provoking conditions within the local workplace (for example, time pressure, understaffing, inadequate equipment, fatigue, and inexperience) and they can create longlasting holes or weaknesses in the defences (untrustworthy alarms and indicators, unworkable procedures, design and construction deficiencies, etc). Latent conditions—as the term suggests—may lie dormant within the system for many years before they combine with active failures and local triggers to create an accident opportunity. Unlike active failures, whose specific forms are often hard to foresee, latent conditions can be identified and remedied before an adverse event occurs. Understanding this leads to proactive rather than reactive risk management.

☐ *We cannot change the human condition, but we can change the conditions under which humans work*

To use another analogy: active failures are like mosquitoes. They can be swatted one by one, but they still keep coming. The best remedies are to create more effective defences and to drain the swamps in which

they breed. The swamps, in this case, are the ever present latent conditions.

Error management

Over the past decade researchers into human factors have been increasingly concerned with developing the tools for managing unsafe acts. Error management has two components: limiting the incidence of dangerous errors and—since this will never be wholly effective—creating systems that are better able to tolerate the occurrence of errors and contain their damaging effects. Whereas followers of the person approach direct most of their management resources at trying to make individuals less fallible or wayward, adherents of the system approach strive for a comprehensive management programme aimed at several different targets: the person, the team, the task, the workplace, and the institution as a whole.[3]

High reliability organisations—systems operating in hazardous conditions that have fewer than their fair share of adverse events—offer important models for what constitutes a resilient system. Such a system has intrinsic "safety health"; it is able to withstand its operational dangers and yet still achieve its objectives.

Some paradoxes of high reliability

Just as medicine understands more about disease than health, so the safety sciences know more about what causes adverse events than about how they can best be avoided. Over the past 15 years or so, a group of social scientists based mainly at Berkeley and the University of Michigan has sought to redress this imbalance by

studying safety successes in organisations rather than their infrequent but more conspicuous failures.[7 8] These success stories involved nuclear aircraft carriers, air traffic control systems, and nuclear power plants (box). Although such high reliability organisations may seem remote from clinical practice, some of their defining cultural characteristics could be imported into the medical domain.

High reliability organizations

[image omitted]

So far, three types of high reliability organisations have been investigated: US Navy nuclear aircraft carriers, nuclear power plants, and air traffic control centres. The challenges facing these organisations are twofold:

• Managing complex, demanding technologies so as to avoid major failures that could cripple or even destroy the organisation concerned

• Maintaining the capacity for meeting periods of very high peak demand, whenever these occur.

The organisations studied[7 8] had these defining characteristics:

• They were complex, internally dynamic, and, intermittently, intensely interactive

• They performed exacting tasks under considerable time pressure

• They had carried out these demanding activities with low incident rates and an almost complete absence of catastrophic failures over several years.

Although, on the face of it, these organisations are far removed from the medical domain, they share important characteristics with healthcare institutions. The lessons to be learnt from these organisations are clearly relevant for those who manage and operate healthcare institutions.

Most managers of traditional systems attribute human unreliability to unwanted variability and strive to eliminate it as far as possible. In high reliability organisations, on the other hand, it is recognised that human variability in the shape of compensations and adaptations to changing events represents one of the system's most important safeguards. Reliability is "a dynamic non-event."[7] It is dynamic because safety is preserved by timely human adjustments; it is a non-event because successful outcomes rarely call attention to themselves.

High reliability organisations can reconfigure themselves to suit local circumstances. In their routine mode, they are controlled in the conventional hierarchical manner. But in high tempo or emergency situations, control shifts to the experts on the spot—as it often does in the medical domain. The organisation reverts seamlessly to the routine control mode once the crisis has passed. Paradoxically, this flexibility arises

in part from a military tradition—even civilian high reliability organisations have a large proportion of ex-military staff. Military organisations tend to define their goals in an unambiguous way and, for these bursts of semiautonomous activity to be successful, it is essential that all the participants clearly understand and share these aspirations. Although high reliability organisations expect and encourage variability of human action, they also work very hard to maintain a consistent mindset of intelligent wariness.[8]

☐ *Blaming individuals is emotionally more satisfying than targeting institution.*

Perhaps the most important distinguishing feature of high reliability organisations is their collective preoccupation with the possibility of failure. They expect to make errors and train their workforce to recognise and recover them. They continually rehearse familiar scenarios of failure and strive hard to imagine novel ones. Instead of isolating failures, they generalise them. Instead of making local repairs, they look for system reforms.

Conclusions

High reliability organisations are the prime examples of the system approach. They anticipate the worst and equip themselves to deal with it at all levels of the organisation. It is hard, even unnatural, for individuals to remain chronically uneasy, so their organisational culture takes on a profound significance. Individuals may forget to be afraid, but the culture of a high reliability organisation provides

them with both the reminders and the tools to help them remember. For these organisations, the pursuit of safety is not so much about preventing isolated failures, either human or technical, as about making the system as robust as is practicable in the face of its human and operational hazards. High reliability organisations are not immune to adverse events, but they have learnt the knack of converting these occasional setbacks into enhanced resilience of the system.

Competing interests: None declared.

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APPENDIX R

PENINSULA GASTROENTEROLOGY

Ernest P. Buxton, III, M.D.
John R. Stephens, M.D.
Ray L. James, Jr., M.D., F.A.C.P.
Frederick M. Gessner, M.D., F.A.C.G.
John W. Boyd, M.D.

June 1, 1999

Dr. Paul Meyers
328 Main Street
Newport News, VA 23601

RE: Betty [redacted]
#8904

Dear Paul,

Thanks for your letter regarding Betty [redacted]. This is a good result. I was very happy that a local surgeon was willing to take on this very complex lady and certainly happy with your fine care. I appreciate your prompt and thorough follow-up notes as well.

Sincerely,

/s/
FREDERICK M. GESSNER, M.D., F.A.C.G.

APPENDIX S

[p.95]

tie at the table is Dr. Kadar, who is counsel for Dr. Meyers who is seated at the table with him. And the members of the panel. If you would, swear in the witness.

(The witness was sworn.)

HEARING OFFICER CARPENTER: Doctor, I would ask if you would state your name for the record and spell your name.

THE WITNESS: Charles A. Miller, M-i-l-l-e-r.

HEARING OFFICER CARPENTER: You may examine, Dr. Kadar.

DR. KADAR: Thank you.

- - -

CHARLES A. MILLER, M.D.,
called as a witness, having been first
duly sworn, was examined and testified
as follows:

DIRECT EXAMINATION

* * *

[p.116]

* * *

DR. GALANTICH: Last question. Are the women of this community, are they better off not having Dr. Meyers do these procedures or do you think they've lost -- we've lost an asset , the community has lost an asset?

THE WITNESS: I think they have definitely lost an asset.

DR. GALANTICH: You didn't feel they were being put in any kind of danger to some of these procedures?

THE WITNESS: No.

* * *

APPENDIX T

RIVERSIDE
OB/GYN & FAMILY CARE

January 8, 1999

Gerald R. Brink
President
Riverside Regional Medical Center
500 J. Clyde Morris Blvd.
Newport News, VA 23601

Dear Mr. Brink:

It has come to my attention that the Executive Committee is reviewing the endoscopy privileges of my colleague, Dr. Paul Meyers. I feel compelled to write in his support. I have known Dr. Meyers since arriving on the peninsula in 1992, and have been associated with him professionally since joining the OB/GYN faculty at Riverside in July, 1994.

During that time, I have been most impressed with his surgical skills, particularly in performing laparoscopic and urogynecologic procedures. In fact, I have often asked Dr. Meyers to assist me in the operating room when facing a difficult case or one I felt may be beyond my level of surgical skills. During the past four years operating with him has increased my proficiency with laparoscopic suturing and dissection and my understanding of defects of the female pelvic floor.

Thanks to his proctoring, I am now able to offer my patients a broader range of laparoscopic and urogynecologic procedures, including suburethral sling procedures and abdominal sacrocolpopexies.

I have also been fortunate to work with Dr. Meyers at our private office, Hilton Women's Care. I have found him to be a conscientious, compassionate physician whose patients are delighted with his care. As he is knowledgeable in all aspects of urogynecology, I refer many of my patients to him for urodynamic or pelvic floor evaluation prior to planning any surgical procedure. He is often able to suggest alternatives to surgery or offers his assistance on a procedure that I would be unable to perform alone. For this, my patients and I are very grateful.

Dr. Meyers is also a dedicated and superb teacher, spending many hours each week patiently instructing our OB/GYN residents in conferences, the outpatient office and the operating room As a faculty member who was once in private practice, I can attest that it is much more difficult and time-consuming to teach a resident to manage a patient's care and perform a surgical procedure than it is to just do it yourself. In fact, the pressure from both internal and external sources to do exactly that is sometimes overwhelming. It is a rare talent to be able to with stand those pressures and continue teaching while still providing adequate patient care. I personally applaud Dr. Meyers efforts at teaching state of the art medicine to our residents.

Thank you for your time in considering my opinion on this matter. I would request that you share this letter

with the other members of the Executive Committee. I feel it would be a grave mistake to suspend Dr. Meyers endoscopy privileges and jeopardize his promising career. Our patients and residents would surely regret such an action.

With regards,

/s/
Karen L. Bruder, M.D., FACOG
Assistant Director, OB/GYN Residency Program
Riverside Regional Medical Center